Medical City
Transplant Institute | Fort Worth

Dear Potential Transplant Candidate, Social Worker, Charge Nurses, and Referring Physicians:

We thank you for your interest in evaluation at Medical City Transplant Institute | Fort Worth (MCTI). All applicable records listed below must be received before evaluation scheduling can occur. Please feel free to use this as a checklist and return it with the application.

☐ Completed application to the program (Must be signed by patient)

☐ Copy of ESRD Medical Evidence Report (2728 form – if on dialysis)

☐ Copy of Driver's License (current) or government issued ID and Social Security Card

☐ Insurance Cards

☐ Resident Card or Certificate of Naturalization (if applicable)

Please fax all documents to MCTI at 469-713-8844. If you have any questions, please call the staff at MCTI at 817-834-8500.

Again, thank you for choosing Medical City Transplant Institute| Fort Worth for your transplant care.

909 9th Ave, Suite 300 - Fort Worth, Texas 76104 - Office (817)834-8500 - Fax (469) 713-8844

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TRANSPLANT APPLICATION

Type of Transplant:
☐ Kidney ☐ Pancreas

NAME:	
Social Security #:	Date of Birth: Sex: ☐ Male ☐ Female
Phone #: Cell #: Email:	
U.S. Citizen: ☐ Yes ☐ No Resident Alien: ☐ Yes ☐ No **Language Preference:**	
Address: Apt #:	City: State: ZIP:
Height: Weight: lbs kg	Spouse: Phone #:
Emergency Contact:	Phone #:

Medicare/Medicaid Information	**(Please include a copy of all insurance cards)**
Medicare ID #:	Effective Date:
Medicaid ID #:	Effective Date:
Texas Kidney Health Plan #:	Date of First Dialysis:

Insurance Information	**Secondary Insurance Information**
Insurance Co.:	Insurance Co.:
Customer Service #:	Customer Service #:
Policy # / I.D. #:	Policy # / I.D. #:
Group #:	Group #:
Address:	Address:
City: State: ZIP:	City: State: ZIP:
Effective Date:	Effective Date:

Referring Agents	
Referring Physician:	Group Practice Name:
Address:	Phone #:
City: State: ZIP:	Fax #:
Dialysis Center:	Nephrologist:
Phone #: Fax #:	Dialysis Center Social Worker:
Type of Dialysis: ☐ Not yet on dialysis ☐ Peritoneal ☐ Hemodialysis ☐ Home Hemodialysis	
Dialysis Days: ☐ M/W/F ☐ T/Th/S	Dialysis Time:
Centers in Evaluation/Listed for Transplant:	
Previous Transplant: ☐ Yes ☐ No	If Yes, Location: Date:

RELEASE OF INFORMATION – Patient Request to Begin Evaluation and Financial Clearance Process:

I request that Medical City Transplant Institute | Fort Worth begin the financial clearance process and transplant evaluation for me. I understand that my insurance companies will be contacted in order to start the transplant process. I authorize my physicians to release my medical records to Medical City Transplant Institute | Fort Worth. I authorize Medical City Transplant Institute | Fort Worth to release any medical information pertaining to my diagnosis and/or treatment, including but not limited to, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), laboratory test results, medical history, treatment, or any other such related information to: 1) Medicare; 2) Medicaid; 3) my insurance company or its designated representatives; 4) any person (s) or entities financially responsible for my care or treatment. The duration of this authorization is indefinite. I understand that this information may be required to be released in order to obtain payment for my medical expenses incurred at Medical City Transplant Institute | Fort Worth. I further authorize release of this information to health care providers associated with my care outside of Medical City Transplant Institute | Fort Worth.

Patient Signature: _____ Witness Signature: _____

Print Name: _____ Date: _____ Print Name: _____ Date: _____

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CURRENT MEDICATION LIST

Patient Name: _____ **Date of Birth: _____**

Today's Date: _____

Please include prescription pills, injections or infusions, over the counter meds, inhalers, nasal sprays, eye drops, eardrops, medicated creams, hormone therapies, & herbals/supplements or natural medicines

	Medication Name	**Strength** (milligrams)	**Quantity** (# of pills taken at a time)	**Frequency** (# of times/day or week)	**Reason for Medication**
#	***Example**: carvedilol*	*25 mg*	*1 tablet*	*Twice a day*	*Blood pressure*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

Medical City Transplant Institute | Fort Worth: 909 9th Avenue, Suite 300, Fort Worth, TX 76104
Office: 817-834-8500 Fax: 469-713-8870

CANCER SCREENING EXAMS

Cancer screenings are the responsibility of the patient to schedule and attend. Please check with your nephrologist or primary care physician to obtain a referral and orders for the colonoscopy and mammogram. Please schedule these tests as soon as possible as these tests take some time to get scheduled and completed and therefore can delay you getting placed on the transplant list.

Always check with the providers to see if they are in your insurance network. You may be eligible for copays based on your insurance benefits as well as findings of the tests. You are not obligated to use these providers, you may use whomever you choose. These are just some suggestions for those who do not have a specialty physician. ***These are provided to you in case you do not know who to use or where to start****. Feel free to speak to your referring physician for other names of providers if needed.*

Mammograms (required yearly for all females 40 years of age and above)

*****Please request referral from your primary care provider to be faxed to: 469.708.4600,***

then call to schedule your appointment.

Solis Mammography

1250 8th Avenue, Suite 130

Fort worth, TX 76104

817-886-0880

http://www.solismammo.com/ (to search for a different place)

PAP Smears (required every 3 year for all females 21 year of age. If hysterectomy, PAP not needed.)

Please refer to your PCP or insurance company for a provider available to you.

GI Consult for a Colonoscopy (required for all patients 45 years of age and above)

*****Please request referral from your primary care provider to be faxed to: 817.885.7811,***

then call to schedule your appointment.

If you have previously completed these tests above, please let your coordinator know. We can request results. If the results are abnormal or not in the timeframe required, your coordinator will let you know if updates are needed. Please contact your coordinator if you have any questions. If you schedule an appointment with the above providers, please write Medical City Transplant Institute of Fort Worth on your record release in their office with the direct fax number of 469-713-8844.